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c. Hospitals that have a Combined MIUR that is equal to or greater than one and one-half standard deviations above the Statewide mean Combined MIUR, but less than two standard deviations above the Statewide mean Combined MIUR, will receive $124.00 per day for hospitals that do not provide obstetrical care and $160.00 per day for hospitals that do provide obstetrical care.
d. Hospitals that have a Combined MIUR that is equal to or greater than two standard deviations above the Statewide mean Combined MIUR will receive $142.00 per day for hospitals that do not provide obstetrical care and $179.00 per day for hospitals that do provide obstetrical care.

10/02 2. Hospitals qualifying under subsection C.1.a. of this Chapter will also receive the following rates:
a. County owned hospitals as defined in Section C.8 of Chapter II, with more than 30,000 Total days will have their rate increased by $455.00 per day.
b. Hospitals that are not county owned with more than 30,000 total days will have their rate increased by ~~$316~~ $330.00 per day.
c. Hospitals with more than 80,000 Total days will have their rate increased by an additional $423.00 per day.
d. Hospitals with more than 4,500 Obstetrical days will have their rate increased by $101.00 per day.
e. Hospitals with more than 5,500 Obstetrical days will have their rate increased by an additional $194.00 per day.
f. Hospitals with an MIUR rate greater than 74 percent will have their rate increased by $147.00 per day.
g. Hospitals with an average length of stay less than 3.9 days will have their rate increased by $41.00 per day.
h. Hospitals with a MUIR greater than the statewide mean plus one standard deviation that are designated a Perinatal Level 2 Center and have one or more obstetrical graduate medical education programs as of July 1, 1999, will have their rate increased by ~~$83~~ $227.00 per day.
i. Hospitals receiving payments under subsection (D)(1)(b) that have an average length of stay less than 4 days will have their rate increased by ~~$41~~ $110.00 per day.
j. Hospitals receiving payments under subsection(D)(1) that have a MIUR greater than 60 percent will have their rate increased by $202.00 per day.
k. Hospitals receiving payments under subsection (D)(1)(d) that have a Medicaid inpatient utilization rate greater than 70 percent and have more than 20,000 days will have their rate increased by ~~$5~~ $11.00 per day.

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10/02 3. Hospitals qualifying under subsection C.1.b. of this Chapter will receive the following rates:
   a. Qualifying hospitals will receive a rate of $303.00 per day.
   b. Qualifying hospitals with the more than 1,500 Obstetrical days will have their rate increased by ~~$206~~$262.00 per day.

10/02 4. Hospitals qualifying under subsection C.1.c. of this Chapter will receive the following rates:
   a. Hospitals will receive a rate of $28.00 per day.
   b. Hospitals located in Illinois and outside of HSA 6, that have a Medicaid inpatient utilization rate greater than 60 percent, will have their rate increased by $55.00 per day.
   c. Hospitals located in Illinois and inside HSA 6, that have a Medicaid inpatient utilization rate greater than 80 percent, will have their rate increased by ~~$394~~ $403.00 per day.
   d. Hospitals that are not located in Illinois that have a Medicaid inpatient utilization rate greater than 45 percent will have their rate increased by $32.00 per day for hospitals that have less than 4,000 total days; or $246.00 per day for hospitals that have greater than 4,000 total days but less than 8,000 total days; or $178.00 per day for hospitals that have greater than 8,000 total days.
   e. Hospitals with more than 3,200 Total admissions will have their rate increased by $248.00 per day.

5. Hospitals qualifying under subsection C.1.d. of this Section will receive the following rates:
   a. Hospitals will receive a rate of $41.00 per day.
   b. Hospitals with a MIUR between 18 percent and 19.75 percent will have their rate increased by an additional $14.00 per day.
   c. Hospitals with a MIUR equal to or greater than 19.75 percent will have their rate increased by an additional $87.00 per day.
   d. Hospitals with a combined MIUR that is equal to or greater than 35 percent will have their rates increased by an additional $41.00 per day.

6. Hospitals qualifying under subsection C1.e above will receive $188.00 per day.

7. Hospitals qualifying under subsection C.1.f. of this Section will receive a rate of $55.00 per day.

8. Hospitals qualifying under subsection C.1.a.iii. above will have their rates multiplied by a factor of two.

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9. DHA Payments
   a. Payments under this subsection D will be made at least quarterly, beginning with the quarter ending December 31, 1999.
   b. ~~c.~~ Payment rates will be multiplied by the Total days.
   c. Total Payment Adjustments
      i. For the CHAP rate period occurring in State fiscal year 2003, total payments will equal the methodologies described above. For the period October 1, 2002 to June 30, 2003, payment will equal the State fiscal year 2003 amount less the amount the hospital received under DHA for the quarter ending September 30, 2002.
      ii. For CHAP rate periods occurring after State fiscal year 2003, total payments will equal the methodologies described above.

   d. ~~b.~~ Payments under this subsection D that are made to disproportionate share hospitals in accordance with Chapter VI.C.7 will be considered to be disproportionate share payments, until September 30, 2002, except for payments made to hospitals as defined in Chapter XIII.

E. Rural Critical Hospital Adjustment Payments (RCHAP)

Rural Critical Hospital Adjustment Payments (RCHAP) shall be made to rural hospitals as defined in Chapter XVI(B(3)) for certain inpatient admissions. The hospital qualifying under this subsection that has the highest number of Medicaid obstetrical care admissions during the CHAP base period shall receive $367,179.00 per year. The Department shall also make a RCHAP adjustment payment to hospitals qualifying under this subsection at a rate that is the greater of:

1. the product of $1,367.00 multiplied by the number of RCHAP Obstetrical Care Admissions in the CHAP base period, or
2. the product of $138.00 multiplied by the number of RCHAP General Care Admissions in the CHAP base period.

F. Total CHAP Payment Adjustments - Each eligible hospital's critical hospital adjustment payment shall equal the sum of the amounts described in sections A, B, C and E of this Chapter. The critical hospital adjustment payments shall be paid at least quarterly.-

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8. Tertiary Care Adjustment
   i. The total annual adjustment to an eligible hospital shall be the sum of the adjustments for which the hospital qualifies under subsections (2) through (7) of this Section multiplied by 0.455.
   ii A total annual adjustment amount shall be paid to the hospital during the Tertiary Care Adjustment Rate Period in installments on, at least, a quarterly basis.

M. Psychiatric Adjustment Payments

1. Qualifying criteria: Psychiatric adjustment payments shall be made to a qualifying hospital, as defined in this subsection (1). A hospital not otherwise excluded under subsection (2) of this Section shall qualify for payment if it meets one of the following criteria as of July 1, 2002:

   a. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; and has a MIUR as described in (5)(e) greater than 60 percent.

   b. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 20 percent; has greater than 325 total licensed beds as described in (5)(b); and has a psychiatric occupancy rate described in (5)(d), greater than 50 percent.

   c. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a., enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 15 percent; has greater than 500 total licensed beds as described in (5)(b); has a psychiatric occupancy rate as described in (5)(d) greater than 35 percent; and has total licensed psychiatric beds described in (5)(c) greater than 50.

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d. The hospital is located in the state of Illinois; is a general acute care hospital with a distinct part unit as defined in Chapter XVI, Section 3.a. enrolled with the Department to provide inpatient psychiatric services; has a current psychiatric care per diem rate less than the statewide psychiatric distinct part unit average default rate; is located outside of HSA 6; has a MIUR as described in (5)(e) greater than 19 percent; has less than 275 total licensed beds as described in (5)(b); has less than 1,000 total psychiatric care days as described in (5)(h); has 40 or less total licensed psychiatric beds as described in subsection (5)(c) of this section; has greater than 6,000 total days as described in subsection (5)(i) of this section.

2. The following five classes of hospitals are ineligible for Psychiatric adjustment payments associated with the qualifying criteria listed in subsections (1)(a) through (1)(d) of this Section:
   a. Hospitals located outside of Illinois.
   b. Hospitals located inside HSA 6.
   c. Psychiatric hospitals, as described in Chapter II, C.1.
   d. Long term stay hospitals, as described in Chapter II,C.4.
   e. A children's hospital, as described in Chapter II.C.3.
3. Psychiatric Adjustment Payment Rates
   a. For a hospital qualifying under subsection (1)(a) the rate is $63.00.
   b. For a hospital qualifying under subsection (1)(b) that :
      i) Has less than 10,000 total days the rate is $78.00.
      ii)Has equal to or greater than 10,000 total days the rate is $125.00.
   c. For a hospital qualifying under subsection (1)(c) the rate is $21.00.
   d. For a hospital qualifying under subsection (1)(d) the rate is $38.00.
4. Payment to a Qualifying Hospital
   a. The total annual adjustment amount to a qualifying hospital shall be the product of the appropriate psychiatric adjustment payment rate, as described in subsection (3) multiplied by total days as described in (5)(i).
   b. The total annual adjustment amount shall be paid to the hospital during the Psychiatric Adjustment Payment Period in installments on, at least, a quarterly basis.
5. Definitions
   a. "HSA" means Health Service Area, as defined by the Illinois Department of Public Health.

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b. "Total Licensed Beds" means, for a given hospital, the number of licensed beds, excluding long term care and substance abuse beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."

c. "Licensed Psychiatric Beds" means, for a given hospital, the number of psychiatric licensed beds, as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."

d. "Psychiatric Occupancy Rate" means, for a given hospital, the psychiatric hospital occupancy rate as listed in the July 25, 2001, Illinois Department of Public Health report entitled "Percent Occupancy by Service in Year 2000 for Short Stay, Non-Federal Hospitals in Illinois."

e. "MIUR" for a given hospital, has the meaning as defined in Chapter VI., Section C.8.e., and shall be determined in accordance with Chapter VI, Sections C.3 and C.6. For purposes of this State Plan, the MIUR determination that was used to determine a hospital's eligibility for Disproportionate Share Hospital Adjustment payments in rate year 2002 shall be the same determination used to determine a hospital's eligibility for Psychiatric Adjustment Payments in the Psychiatric Adjustment Payment Period.

f. "Psychiatric Adjustment Payment base year" means the 12-month period beginning on July 1, 2000, and ending on June 30, 2001.

g. "Psychiatric Adjustment Payment Period" means, beginning October 1, 2002, the 9 month period beginning October 1 ending June 30 of the following year, and beginning July 1, 2003 the 12 month period beginning July 1 of the year and ending June 30 of the following year.

h. "Total Psychiatric care days" means, for a given hospital, the sum of days of inpatient psychiatric care, as defined in Chapter XV, Section H.4., provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the psychiatric adjustment payment base year that were adjudicated by the Department through June 30, 2001.

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i. "Total days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the psychiatric adjustment payment base year base year that were adjudicated by the Department through June 30, 2001.

j. "Psychiatric Care Average Length of Stay" mean the quotient, the numerator of which is the number of psychiatric care days in the Psychiatric Adjustment Payment base year, the denominator of which is the number of admissions in the Psychiatric Adjustment Payment base year.

N. Rural Adjustment Payments

1. Qualifying criteria: Rural Adjustment Payments shall be made to all qualifying general acute care hospitals which are designated as a Critical Access Hospital or a Necessary Provider, as defined by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F, as of the first day of July in the Rural Adjustment Payment rate period.

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2. Rural Adjustment Rates:

a. Inpatient component: For a hospital qualifying under subsection (1) of this Section, a Rural Adjustment Payment inpatient component shall be calculated as follows;

i. Total inpatient payments as described in subsection (4)(b) of this section, shall be divided by the total inpatient days, as described in subsection (4)(c) of this section, to derive an inpatient payment per day.

ii. Total inpatient charges, associated with inpatient days as described in subsection (4)(c) of this section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (4)(a) of this section, to derive total inpatient cost.

iii. Total inpatient coverage cost as defined in subsection (2)(a)(ii) of this section, are divided by the total inpatient days, as described in subsection (4)(c) of this section, to derive an inpatient cost per day.

iv. Inpatient payment per day, as defined in subsection (2)(a)(i) of this section, shall be subtracted from the inpatient cost per day, as described in subsection (2)(a)(iii) of this section, to derive an inpatient cost coverage deficit per day. The minimum result shall be no lower than zero.

v. Inpatient cost coverage deficit per day, as described in subsection (2)(a)(iv) of this section, shall be multiplied by the total inpatient days, as described in subsection (4)(c) of this section, to derive a total hospital specific inpatient cost coverage deficit.

vi. The inpatient cost deficits, as described in subsection (2)(a)(v) of this section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year inpatient cost deficit.

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METHODS AND STANDARDS FOR ESTABLISHING INPATIENT RATES FOR HOSPITAL REIMBURSEMENT: MEDICAL ASSISTANCE-GRANT (MAG). AND MEDICAL ASSISTANCE-NO GRANT (MANG).

b. Payment Methodology: A $7 million total pool shall be allocated to the program, and proportioned between inpatient services and outpatient services as defined in Attacment 4.19-B(1)(n) as follows:

i. The total inpatient cost coverage deficit as described in subsection (2)(a)(vi) of this section, is added to the total outpatient cost coverage deficit as described in subsection Attachment 4.19-B(1)(n)(b)(i)(D), to derive a total Rural Adjustment Payment base year deficit.

ii. The inpatient pool allocation percentage shall be the quotient, the numerator of which is the total inpatient cost deficit, as described in subsection (2)(a)(vi) of this section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in (2)(b)(i) of this section.

iii. An inpatient pool allocation shall be the product of the inpatient pool allocation percentage, as described in subsection (2)(b)(ii) of this section, multiplied by the $7 million pool, as described in (2)(b) of this section.

iv. An inpatient residual cost coverage factor shall be the quotient, the numerator of which shall be the inpatient pool allocation, as described in subsection (2)(b)(iii) of this section, the denominator of which shall be the total inpatient cost deficit as described in subsection (2)(a)(vi) of this section.

v. Hospital specific inpatient cost coverage adjustment amount, shall be the product of the inpatient residual cost coverage factor, as described in subsection (2)(b)(iv) of this section, multiplied by the hospital specific inpatient cost coverage deficit, as described in subsection (2)(a)(v) of this section.

3. Payment to a Qualifying Hospital

a. The total annual adjustment amount to a qualified hospital shall be the inpatient cost coverage adjustment amount, as described in subsection (2)(b)(v) of this section.

b. The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (4)(e) of this section on at least a quarterly basis.

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4. Definitions.

a. "Hospital cost to charge ratio", means the quotient, the numerator of which is the cost as reported on Form HCFA 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form HCFA 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, for SFY 2004 the hospital's fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.

b. "Inpatient Payments", shall mean all payments associated with total days provided, as described in subsection (4)(c) of this section, and all quarterly adjustment payments paid, as described in the State Plan.

c. "Total Days" means, for a given hospital, the sum of days of inpatient hospital service provided to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding days for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for admissions occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.

d. Rural Adjustment Payment base year" means for the Rural Adjustment Payment rate period beginning October 1, 2002, State fiscal year 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, State fiscal year 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.

e. "Rural Adjustment Payment Rate Period" means, beginning October 1, 2002, the 9 month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003 the 12 month period beginning July 1 of the year and ending June 30 of the following year.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE - BASIS FOR REIMBURSEMENT

n. Rural Adjustment Payments - Outpatient Component

a. Qualifying criteria: Rural Adjustment Payments shall be made to all qualifying general acute care hospitals which are designated as a Critical Access Hospital or a Necessary Provider, as defined by the Illinois Department of Public Health, in accordance with 42 CFR 485, Subpart F, as of the first day of July in the Rural Adjustment Payment rate period.

b. Rural Adjustment Rates:

i. Outpatient component: For a hospital qualifying under subsection (a) of this Section, a Rural Adjustment Payment outpatient component shall be calculated as follows;

A. Total outpatient payments, as defined in subsection (d)(ii) of this section, shall be divided by the total outpatient services, as described in subsection (d)(iii) of this section, to derive an outpatient payment per service unit.

B. Total outpatient charges, associated with outpatient services, as defined in subsection (d)(iii) of this section, shall be multiplied by the hospital's cost to charge ratio, as described in subsection (d)(i) of this section, to derive total outpatient cost.

C. Total outpatient costs, as defined in subsection (b)(i)(B) of this section, are divided by the total outpatient services, as described in subsection (d)(iii) of this section to derive an outpatient cost per service unit.

D. Outpatient payment per service unit, as defined in subsection (b)(i)(A) of this section, shall be subtracted from the outpatient cost per service unit, as described in subsection (b)(i)(c) of this section, to derive an outpatient cost coverage deficit per service unit. The minimum result shall be no lower than zero.

E. Outpatient cost coverage deficit per service unit, as described in subsection (b)(i)(d) of this section, shall be multiplied by the total outpatient services, as described in subsection (d)(iii) of this section, to derive a total hospital specific outpatient cost coverage deficit.

F. The outpatient cost coverage deficits, as described in subsection (b)(i)(E) of this section, for all qualifying hospitals, shall be summed to determine an aggregate Rural Adjustment Payment base year outpatient cost deficit.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE BASIS FOR REIMBURSEMENT

ii. Payment Methodology: A $7 million total pool shall be allocated to the program, and proportioned between inpatient services Attachment 4.19-A (I)(N)(2)(b) and outpatient services as follows:

A. The total outpatient cost coverage deficit as described in subsection (b)(i)(F) of this section, is added to the total inpatient cost coverage deficit as described in Attachment 4.19-A(I)(N)(2)(a)(vi), to derive a total Rural Adjustment Payment base year deficit.

B. The outpatient pool allocation percentage shall be the quotient, the numerator of which is the total outpatient cost deficit, as described in subsection (b)(i)(D) of this section, the denominator of which is the total Rural Adjustment Payment base year deficit, as described in (b)(ii)(F) of this section.

C. Outpatient pool allocation shall be the product of the outpatient pool allocation percentage, as described in subsection (b)(ii)(B) of this section, multiplied by the $7 million pool, as described in (b)(ii) of this section.

D. An outpatient residual cost coverage factor shall be the quotient, the numerator of which shall be the outpatient pool allocation, as described in subsection (b)(ii)(c) of this section, the denominator of which shall be the total outpatient cost deficit as described in subsection (b)(i)(F) of this section.

E. Hospital specific outpatient cost coverage adjustment amount, shall be the product of the outpatient residual cost coverage factor, as described in subsection (b)(ii)(D) of this section, multiplied by the hospital specific outpatient cost coverage deficit, as described in subsection (b)(i)(E) of this section.

c. Payment to a Qualifying Hospital

i. The total annual adjustment amount to a qualified hospital shall be the outpatient cost coverage adjustment amount, as described in subsection (b)(ii)(E) of this section.

ii. The total annual adjustment amount shall be paid to the hospital during the Rural Adjustment Payment rate period, as described in subsection (d)(iv) of this section on at least a quarterly basis.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPE OF CARE BASIS FOR REIMBURSEMENT

d. Definitions.

i. "Hospital cost to charge ratio", means the quotient, the numerator of which is the cost as reported on Form HCFA 2552, worksheet C, Part 1, column 1, row 101, the denominator of which is the charges as reported on Form HCFA 2552, worksheet C, Part 1, column 8, row 101. The base year for State Fiscal Year (SFY) 2003 shall be the hospital's fiscal year 1999 Medicare cost report, for SFY 2004 the hospital's fiscal year 2000 cost report shall be utilized. The base year for any SFY shall be determined in this manner.

ii. "Outpatient Payments", shall mean all payments associated with total outpatient services provided, as described in subsection (d)(iii) of this section, and all quarterly adjustment payments paid, as described in the State Plan.

iii. "Total Outpatient Services" means the number of outpatient services provided during the Rural Adjustment Payment base year, to recipients of medical assistance under Title XIX of the federal Social Security Act, excluding services for individuals eligible for Medicare under Title XVIII of that Act (Medicaid/Medicare crossover days), as tabulated from the Department's claims data for services occurring in the Rural Adjustment Payment base year that were subsequently adjudicated through the last day of June preceding the Rural Adjustment Payment rate period.

iv. Rural Adjustment Payment base year" means for the Rural Adjustment Payment rate period beginning October 1, 2002, State fiscal year 2001; for the Rural Adjustment Payment rate period beginning July 1, 2003, State fiscal year 2002. The Rural Adjustment Payment base year for subsequent rate periods shall be determined in this manner.

v. "Rural Adjustment Payment Rate Period" means, beginning October 1, 2002, the 9 month period beginning October 1 and ending June 30 of the following year, and beginning July 1, 2003 the 12 month period beginning July 1 of the year and ending June 30 of the following year.